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Tan Eng Siew & Anor v Dr Jagjit Singh Sidhu & Anor

HIGH COURT (KUALA LUMPUR) — CIVIL SUIT NO S1–22–178 OF 2000
JAMES FOONG J
29 AUGUST 2005

B

Tort — Professional negligence — Medical practitioner — Third party claim by husband for expenses — Whether first plaintiff had a cause of action

C

Tort — Professional negligence — Medical practitioner — Claim against hospital — Whether second defendant vicariously liable for the action of first defendant — Whether second defendant independently liable to second plaintiff

D

Tort — Professional negligence — Medical practitioner — Claim against — Whether first defendant negligent in treating, managing and caring second plaintiff — Standard of care and skill expected — Whether first defendant acted in accordance with body of skilled men

E

The first plaintiff was the husband of the second plaintiff. In early January 1997, the second plaintiff, who was then 65 years of age, had a fall. She fractured the neck of her left femur with displacement. She also had a crack fracture of her tibia. Initially, she was admitted to University Malaya Hospital but since this hospital could not perform an operation on her soonest, she sort treatment from the second defendant. After being X-rayed at the emergency ward of the second defendant, she was referred to the first defendant for treatment. Dissatisfied with the medical treatment, management and care administered by the first defendant during her treatment with the first defendant, and insisting that the second defendant was vicariously liable to the action of the first defendant, the plaintiffs brought this medical negligence suit against these two defendants. Besides, the second defendant was also being sued independently for: (a) permitting the first defendant and other second defendant's hospital staff to continue with a course of treatment on the second plaintiff, which they knew was useless or at best purely cosmetic; (b) failing to provide a system of medical governance and audit for the purpose of the second plaintiff's safety and quality of medical treatment; (c) permitting the first defendant to monopolize the second plaintiff and continue a course of treatment which the second defendant knew or ought to have known was useless. In the statement of claim, the first plaintiff claimed that he was entitled to damages from the defendants as a result of the necessity for him to give up his part time job as a cashier to look after the second plaintiff. Besides, he was also claiming special damages expanded on the second plaintiff's medical fees. The second plaintiff's claim was more straightforward. She was claiming for pain, suffering and loss of amenities together with special damages.

I

Held, first defendant was negligent in treating, managing and caring for the second plaintiff and therefore liable to pay damages which were to be assessed:

(1) The first plaintiff had no cause of action against both the first defendant, as the alleged direct wrongdoer, and against the second defendant, for being alleged

to be vicariously liable for the actions of the first defendant (see para 32); *Lai Chi Kay & Ors v Lee Kuo Shin* [1981] 2 MLJ 167; *Ahmad Daman Huri bin Hussein v Koo Chin Yau* [1990] 3 MLJ 53 followed. A

(2) As regards to whether the second defendant was vicariously liable for the alleged wrongdoing of the first defendant, three requirements must be satisfied. First, there must be a wrongful, or tortious action. Second, there must exist a special relationship that is recognized by law between the person alleged to be vicariously liable and the tortfeasor. Third, the tort is committed within the course of employment (see para 33). B

(3) The first defendant was, at the material time a consultant with clients of his own. Though he was attached to the second defendant, it was only an arrangement to use the second defendant's facilities such as running his clinic there, and using its operating facilities. For this, the first defendant had to pay and the form of payment was a percentage of the first defendant's charges to his clients. These clients were exclusively that of the first defendant who had a full control in the form of treatment, management, and care to be administered upon them as well as the amount of fees to be charged (see para 39). C D

(4) Though there was no denial that when the second plaintiff was first admitted to the second defendant's hospital for treatment, and the second defendant had proposed the first defendant, but this does not mean that the second defendant had control over the first defendant. This exercise was only a recommendation by the second defendant to the second plaintiff to take on the services of the first defendant. The second plaintiff could reject or refuse this recommendation of the second defendant. And similarly, the same option was opened to the first defendant. And when both the second plaintiff and the first defendant agreed to accept each other, they entered into an independent contract with each other. The second defendant had absolutely no control over the terms and conditions of this contract relating to either the type of services to be provided or regarding the terms of payment for it (see para 39). E F

(5) Though the second plaintiff had stressed that the first defendant was at all material time a shareholder of the second defendant but he was not in the management of the second defendant. The first defendant was not in control over the affairs of the second defendant. He only practiced medicine by using the premises of the second defendant for which, as stated, he paid for it. At best, being just a shareholder, the first defendant was merely an investor. The first defendant was an independent contractor (see para 39). G H

(6) With the failure of the second plaintiff to establish this element of 'special relationship' between the first and second defendants, there was no necessity for the court to proceed to analyze the other two factors necessary to attach vicarious liability. This one factor alone, if not satisfied, which was the case here, was sufficient to justify the dismissal of the second plaintiff's claim against the second defendant for vicariously liable for the alleged tortious wrong of the first defendant (see para 39). I

(7) There was no ground to support the second plaintiff's claim that the second defendant was negligent in the form and manner as set out in her claim against

A the second defendant independently. As explained and decided, the first defendant was at the material time an independent contractor and had his own set up in the treatment, management and care of the second plaintiff. The second defendant only provided the premises and operating facilities for which the first defendant paid for its use. The second defendant had no control over
B the course or form of treatment, management and care administered by the first defendant on the second plaintiff. If the second plaintiff was not satisfied with the services of the first defendant she could change to another doctor or specialist. She had a free choice (see para 40).

(8) Regarding claims that the second defendant's staff had continued with a course
C of treatment which the second defendant's servants and agents knew or ought to have known was useless or at best purely cosmetic, The court is of the view that minus the first defendant, the only other people who attended to the second plaintiff from the second defendant were: (a) the operating staff; (b) the nurses at the ward; (c) the medical attendants who dressed her wound and; (d)
D the physiotherapist. In respect of the first two categories, there was absolutely no evidence led by the second plaintiff against them. When questions were posted to the second plaintiff as well as her relevant witnesses as to whether they were satisfied with the services so provided by the later two categories, they all answered in the positive. In any event, the dressing by the second defendant's medical assistants on the second plaintiff as well as those exercises
E encouraged by the physiotherapist on the second plaintiff were all done on the instructions of the first defendant (see para 41).

(9) As early as March 1997, the first defendant should have called for a C & S test. This would disclose whether the second plaintiff had a superficial wound or a
F deep seated one, but the first defendant procrastinated. Besides, there was no X-ray taken of the second plaintiff, which may be another form of investigation into the seriousness of the second plaintiff's medical condition until insisted upon by the second plaintiff's daughter as late as 24 June 1997. And even after such X-ray was developed where the first defendant admitted in evidence the presence of bone cement outside the femur that he should have removed
G during the second operation, the first defendant was unable to ascertain that the second plaintiff was suffering from deep infection of her left leg. This was borne out by the advice of the first defendant to the second plaintiff to continue walking and that there was nothing wrong with the second plaintiff. The first defendant should have suspected by then that these foreign objects
H may be the culprit of the recalcitrant wound. These delayed actions of the first defendant in diagnosing and treating the second plaintiff, amounted to negligence on the part of the first defendant (see para 59).

(10) Though there may be the time period of eight months between the clinic visit of 21 July 1997 to 19 March 1998, it was not due to the fault of the second
I plaintiff for refusing to see the first defendant. The first defendant had assured her and her family members all along that there was nothing wrong with her, and this was even having examined the X-ray pictures on the 24 June 1997, and not fixing another appointment on 21 July 1997 for follow-up visit. Despite this absence from clinic visit, the first defendant still saw the second plaintiff at the dressing enclosure of the hospital. From the totality of these

facts, the first defendant cannot use this excuse of long absence to exempt himself from liability when in the first place he had failed to diagnose the deep infection in the left thigh of the second plaintiff which was most likely caused by the bone cement left or spilled into the soft tissue during the second operation as a result of his act at the earliest date when he examined the second plaintiff who persistently complained of pain in her left thigh couple with continuous discharges from her wound (see para 62).

(11) The first defendant advanced the reason that the second plaintiff was parsimonious when she refused to see him for such long periods and instead preferring to a less expensive alternative: being dressed by the hospital attendant. This accusation was not proven. Firstly, the second plaintiff had frequently sort the services of the first defendant, but the first defendant had constantly and repeatedly advised the second plaintiff to continue with such dressing. Obediently, the second plaintiff complied to the very end. Secondly, as evidence revealed, these hospital assistants do report back to the doctor who referred the patient to them, and as disclosed, the first defendant had also seen the second plaintiff occasionally during these dressing sessions. Thirdly, these dressings did not come free (see para 63).

[Bahasa Malaysia summary

Plaintif pertama adalah suami kepada plaintif kedua. Pada awal Januari 1997, plaintif kedua, yang pada masa itu berumur 65 tahun, telah terjatuh. Beliau mengalami keretakan pada pangkal tulang femur dan terseliuh. Beliau juga mengalami keretakan pada tulang tibia. Pada mulanya beliau dimasukkan ke Hospital Universiti Malaya tetapi memandangkan hospital tersebut tidak boleh menjalankan pembedahan terhadapnya secepat mungkin, beliau mendapatkan rawatan daripada defendan kedua. Selepas di x-ray di wad kecemasan defendan kedua, beliau telah dirujuk kepada defendan pertama untuk rawatan. Kerana tidak berpuas hati dengan rawatan perubatan. Pengurusan dan jagaan yang diberikan oleh defendan pertama semasa rawatannya dengan defendan pertama, dan bertegas menyatakan bahawa defendan kedua adalah bertanggungan secara vikarius terhadap tindakan defendan pertama, plaintif memulakan tindakan kecuaian perubatan terhadap kedua-dua defendan. Selain itu, defendan kedua juga disaman secara bersendirian kerana: (a) membenarkan defendan pertama dan kakitangan lain hospital defendan kedua untuk meneruskan rawatan terhadap plaintif kedua, yang mana mereka ketahui tidak berguna atau hanya untuk tujuan kosmetik; (b) gagal untuk menyediakan satu sistem kawalan perubatan dan audit bagi tujuan keselamatan defendan kedua dan kualiti rawatan perubatan; (c) membenarkan defendan pertama untuk memonopoli plaintif kedua dan meneruskan rawatan yang mana defendan kedua tahu atau sepatutnya tahu adalah tidak berguna. Dalam Penyataan Tuntutan, plaintif pertama menyatakan bahawa beliau berhak untuk mendapatkan ganti rugi daripada defendan-defendan kerana beliau terpaksa berhenti kerja sementaranya sebagai juruwang untuk menjaga plaintif kedua. Selain daripada itu, beliau juga menuntut ganti rugi khas bagi bayaran perubatan plaintif kedua. Tuntutan plaintif kedua adalah lebih jelas. Beliau membuat tuntutan untuk kesakitan, kesengsaraan dan kehilangan kemudahan bersama dan ganti rugi khas.

Diputuskan, defendan pertama adalah cuai dalam merawat, mengurus dan menjaga plaintif kedua dan oleh itu bertanggungjawab untuk membayar ganti rugi yang akan dinilai:

(1) Plaintif pertama tidak mempunyai kausa tindakan terhadap kedua-dua defendan pertama, sebagai pelaku kesalahan terus, dan terhadap defendan kedua, sebagai pihak yang bertanggungan secara vikarius bagi tindakan defendan pertama (lihat perenggan 32); *Lai Chi Kay & Ors v Lee Kuo Shin* [1981] 2 MLJ 167; *Ahmad Daman Huri bin Hussein v Koo Chin Yau* [1990] 3 MLJ 53 diikut.

(2) Berkenaan sama ada defendan kedua bertanggungan secara vikarius atas kesalahan defendan pertama, tiga keperluan perlu dipenuhi. Pertama, perlu terdapat tindakan tort yang salah. Kedua, perlu wujud hubungan khas yang diakui oleh undang-undang di antara orang yang dikatakan bertanggungan secara vikarius dan pelaku tort. Ketiga, tort tersebut dilakukan semasa bekerja (lihat perenggan 33).

(3) Defendan pertama, pada masa matan adalah pakar runding yang mempunyai pelanggannya sendiri. Walaupun beliau bekerja dengan defendan kedua, ianya hanyalah untuk menggunakan kemudahan defendan kedua seperti menjalankan kliniknya, dan menggunakan kemudahan pembedahannya. Untuk ini, defendan kedua perlu membayar dan bayaran dibayar secara peratusan daripada bayaran yang dikenakan oleh defendan pertama kepada pelanggannya. Pelanggan-pelanggan ini adalah secara eksklusifnya kepunyaan defendan pertama yang mempunyai kawalan penuh ke atas rawatan, pengurusan, dan penjagaan yang diberikan terhadap mereka dan juga bayaran yang dikenakan (lihat perenggtan 39).

(4) Walaupun tiada penafian bahawa apabila plaintif kedua dimasukkan ke hospital defendan kedua untuk rawatan, dan defendan kedua telah mencadangkan defendan pertama, ini tidak bermakna bahawa defendan kedua mempunyai kawalan ke atas defendan pertama. Langkah ini hanyalah satu saranan oleh defendan kedua kepada plaintif kedua untuk mendapatkan perkhidmatan defendan pertama. Plaintif kedua boleh menolak atau menerima cadangan defendan kedua itu. Begitu juga, pilihan yang sama diberikan kepada defendan pertama. Dan apabila kedua-dua plaintif kedua dan defendan pertama bersetuju untuk menerima antara satu sama lain, mereka memasuki satu kontrak yang berasingan di antara mereka. Defendan kedua langsung tidak mempunyai kawalan terhadap terma-terma dan syarat-syarat berkenaan dengan terma pembayarannya (lihat perenggan 39).

(5) Meskipun plaintif kedua telah menekankan bahawa defendan pertama adalah pada setiap masa matan pemegang saham defendan kedua tetapi beliau bukan di bawah pengurusan defendan kedua. Defendan pertama tiada kawalan terhadap urusan defendan kedua. Beliau hanya mengamalkan perubatan dengan menggunakan premis defendan kedua yang mana, seperti dinyatakan, beliau membayar untuknya. Lebih-lebih pun, sebagai seorang pemegang saham sahaja, defendan pertama adalah dan hanya seorang pelabur. Defendan pertama adalah kontraktor yang bebas(lihat perenggan 39).

(6) Dengan kegagalan plaintif kedua untuk membuktikan elemen 'hubungan istimewa' ini antara defendan-defendan pertama dan kedua maka adalah tidak perlu untuk mahkamah terus menganalisis dua faktor lain yang diperlukan untuk menunjukkan adanya liabiliti vikarius. Dengan faktor ini sahaja, jika tidak dipenuhi, yang mana berlaku dalam kes ini, adalah memadai untuk menjustifikasikan penolakan tuntutan plaintif kedua terhadap defendan kedua untuk liabiliti vikarius untuk kesalahan tort defendan pertama yang dikatakan itu (lihat perenggan 39).

(7) Tiada alasan untuk menyokong tuntutan plaintif kedua bahawa defendan kedua adalah cuai dalam bentuk dan cara yang ditetapkan dalam tuntutannya terhadap defendan kedua secara berasingan. Seperti yang dijelaskan dan diputuskan, defendan pertama pada masa matan adalah seorang kontraktor yang bebas dan mempunyai perniagaan beliau sendiri dalam rawatan, pengurusan dan penjagaan plaintif kedua. Defendan kedua hanya menyediakan premis dan kemudahan operasi yang mana penggunaannya dibayar oleh defendan pertama. Defendan kedua tiada kawalan ke atas proses atau cara rawatan, pengurusan dan penjagaan yang dilakukan oleh defendan pertama ke atas plaintif kedua. Jika plaintif kedua tidak berpuas hati dengan khidmat defendan pertama, beliau boleh menukar kepada doktor atau pakar lain. Beliau bebas membuat pilihan (lihat perenggan 40).

(8) Berhubung dakwaan bahawa staf defendan kedua telah meneruskan proses rawatan yang pekerja dan ejen defendan kedua tahu atau patut ketahui adalah tidak berguna atau yang sebenarnya hanya bersifat kosmetik, mahkamah berpendapat bahawa dengan tidak mengambil kira defendan pertama, mereka yang lain merawat plaintif kedua dari defendan kedua hanyalah: (a) staf bedah; (b) jururawat di wad; (c) atendan perubatan yang merawat luka beliau; dan (d) pakar fisioterapi. Berhubung dua kategori yang pertama, tiada keterangan langsung yang dikemukakan oleh plaintif kedua terhadap mereka. Apabila persoalan-persoalan diutarakan kepada plaintif kedua dan juga kepada saksi-saksi relevan beliau berhubung sama ada mereka berpuas hati dengan khidmat yang disediakan oleh dua kategori berikutnya, semuanya menjawab secara positif. Dalam apa keadaan pun, balutan oleh pembantu perubatan defendan kedua dan juga latihan yang digalakkan oleh ahli fisioterapi ke atas plaintif kedua kesemuanya dilakukan atas arahan defendan pertama (lihat perenggan 41).

(9) Seawal Mac 1997, defendan pertama sepatutnya telah melakukan ujian C & S. Ini dapat menunjukkan sama ada plaintif kedua mempunyai luka luaran atau yang dalam. Namun defendan pertama telah melengah-lengahkannya. Bahkan, tiada X-ray diambil ke atas plaintif kedua, yang merupakan satu cara untuk menyelidik keseriusan keadaan perubatan plaintif kedua sehingga didesak oleh anak perempuan plaintif kedua pada 24 Jun 1997. Dan jika pun selepas X-ray sedemikian diperoleh yang mana defendan pertama telah mengaku dalam keterangan tentang kewujudan simen tulang yang terdapat di bahagian luar tulang femur yang patut beliau keluarkan semasa pembedahan kedua, defendan pertama masih tidak dapat menentukan yang plaintif kedua mengalami jangkitan dalam pada kaki kirinya. Oleh demikian defendan

pertama menasihatkan plaintif kedua untuk terus berjalan dan bahawa tiada apa-apa yang tidak kena dengan plaintif kedua. Defendan pertama sepatutnya syak sesuatu bahawa terdapat objek asing yang mungkin mengakibatkan luka yang besar itu. Tindakan lambat defendan pertama dalam mendiagnosis dan merawat plaintif, membentuk kecuaian di pihak defendan pertama (lihat perenggan 59).

(10) Walaupun terdapat tempoh masa lapan bulan antara lawatan klinik pada 21 Julai 1997 hingga 19 Mac 1998, ia bukan disebabkan oleh keengganan plaintif kedua untuk berjumpa defendan pertama. Defendan pertama sentiasa meyakinkan beliau dan keluarganya bahawa beliau tidak apa-apa, dan ini setelah gambaran X-ray diperiksa pada 24 Jun 1997, dan tidak menetapkan temu janji lain pada 21 Julai 1997 untuk lawatan lanjut. Meskipun beliau tidak hadir untuk lawatan klinik, defendan pertama masih berjumpa dengan plaintif kedua di bilik balutan hospital itu. Berdasarkan keseluruhan fakta tersebut, defendan pertama tidak bolah menggunakan alasan tidak hadir yang lama untuk mengecualikan dirinya daripada liabiliti yang mana pada mula lagi beliau telah gagal untuk mendiagnosis jangkitan yang dalam pada paha kiri plaintif kedua yang berkemungkinan besar disebabkan oleh simen tulang yang tertinggal atau tertumpah ke dalam tisu lembut semasa pembedahan kedua akibat daripada tindakan beliau pada tarikh terawal apabila beliau memeriksa plaintif kedua yang berterusan mengadu tentang kesakitan pada paha kirinya yang terdapat lelehan berterusan dari luka tersebut (lihat perenggan 62).

(11) Defendan pertama mengemukakan alasan bahawa plaintif kedua seorang yang kedekut apabila beliau enggan berjumpa dengannya untuk tempoh yang lama dan sebaliknya lebih suka alternatif yang tidak mahal: seperti diberi balutan oleh atendan hospital. Tuduhan ini tidak dibuktikan. Pertamanya, plaintif kedua kerap meminta khidmat defendan pertama, tetapi defendan pertama sentiasa dan berulang kali menasihatkan plaintif kedua terus menggunakan balutan itu. Dengan patuh, plaintif kedua mematuhinya. Keduanya, seperti keterangan yang telah dikemukakan, pembantu-pembantu hospital tersebut melaporkan diri kepada doktor yang merujukkan pesakit kepada mereka, dan seperti yang didedahkan, defendan pertama juga melihat plaintif kedua kadang kala sewaktu sesi balutan berlaku. Ketiganya, balutan tersebut bukannya percuma. Plaintif kedua atau suaminya, plaintif pertama membayar untuknya. Dan jika diambil kira bilangan hari yang dilanjutkan untuk ini, jumlahnya tidak boleh dikatakan tidak ketara (lihat perenggan 63).]

Notes

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 2000 Reissue) paras 945–1013.

Cases referred to

Ahmad Daman Huri bin Hussein v Koo Chin Yau [1990] 3 MLJ 53 (folld)
Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (refd)
Christopher Rogers v Maree Lynette Whitaker [1993] 1 CLJ 449 (refd)
Dr Soo Fook Mun v Foo Fio Na & Anor and another appeal [2001] 2 MLJ 193 (refd)
Lai Chi Kay & Ors v Lee Kuo Shin [1981] 2 MLJ 167 (folld)

Ready Mixed Concrete (South East) Ltd v Minister of Pensions and National Insurance [1968] 2 QB 497 (refd)
Short v J & W Henderson Ltd (1946) 62 TLR 427 (refd)
Stevenson, Jordan & Harrison Ltd v MacDonald & Evans [1952] 1 TLR 101 (refd)

PS Gill (Harjit Singh with him) (Gill & Tang) for the plaintiffs.
PS Ranjan (MS Dhillon with him) (PS Ranjan & Co) for the first defendant.
Felix Raj (Anad & Noraini) for the second defendant.

James Foong J:

Introduction

[1] The first plaintiff is the husband of the second plaintiff.

[2] In early January 1997, the second plaintiff, who was then 65 years of age, had a fall. She fractured the neck of her left femur with displacement. She also had a crack fracture of her tibia. Initially, she was admitted to University Malaya Hospital but since this hospital could not perform an operation on her soonest, she sort treatment from the second defendant. After being X-rayed at the emergency ward of the second defendant, she was referred to the first defendant for treatment.

[3] On 13 January 1997, the first defendant performed a surgery on the second plaintiff known as 'Thompson hemiarthroplasty'. This involved the insertion of a metal prosthesis into the second plaintiff's femur shaft. In order for the prosthesis to sit well, the femur shaft should be properly and sufficiently reamed to accommodate the prosthesis where the neck of this metal insertion would rest on the calcar. Once this prosthesis is properly inserted and with its round head reduced into the hip socket, the second plaintiff should be able to walk without any pain.

[4] Soon after this operation (which I shall refer to as the first operation), the second plaintiff was instructed by the first defendant to ambulate and bear weight on her legs. She did, but according to her, she experienced pain. Going by the notes of the first defendant, this patient was able to walk with the aid of a walker. It is not in dispute that it is an accepted medical practice to instruct the patient to ambulate and to bear weight after this kind of operation to avoid muscle wastage and bedsore.

[5] After the second plaintiff was discharged, she attempted to walk with the aid of a walker or human assistance but she said that she continued to experience severe pain. Then on 1 February 1997, she fell. This time she fractured the lesser trochanter of her femur, which warranted a second operation. This second operation was undertaken by the first defendant. Before this second operation (second operation) was carried out on 3 February 1997, the second plaintiff was X-rayed on the affected part. It shows fracture of the lesser trochanter causing the mouth of the femur to become large, and the prosthesis though has moved down into her femur has become unstable.

[6] The second operation was carried out on 3 February 1997. In this operation, the first defendant first removed the prosthesis. He then re-inserted it. This time he used bone cement to bind the prosthesis to the femur. This would give a stronger hold of the prosthesis in the femur. To avoid any leakage of the bone cement onto

A the surrounding tissues, and to wait for the hardening of the cement he held gauze over the area. It is pertinent to point out that medically, as disclosed by the evidence of doctors who testified in this case that bone cement, being a foreign object, if left in the surrounding tissues may cause infection.

[7] On 6 February 1997, the second plaintiff was discharged. She was advised by
B the first defendant to ambulate and to bear weight. At time of discharge, she was supplied with antibiotic and pain killer. Antibiotic was prescribed because the second plaintiff was a diabetic and was more prone to infection.

[8] On 8 February 1997, the second plaintiff's wound in the area operated became infected with discharges. Unable to secure the immediate service of the first
C defendant, due to the Chinese New Year holiday, the second plaintiff sort medical attention from one Dr Siddanna, a private practitioner, who made a house call on the second plaintiff. The wound, with stitches still intact, was cleaned and dressed.

[9] On 20 February 1997, the first defendant saw the second plaintiff. According to the first defendant, he noted that the wound has cleared and is clean. However, he
D instructed the second plaintiff to continue with dressing. For dressing, the second plaintiff would have to be at the second defendant's hospital where medical assistants of the second defendant would attend to such task. The first defendant did not provide such service in his own clinic.

[10] Then on 28 February 1997, the first defendant structured the second
E plaintiff's wound and considered the infection under control.

[11] But on 8 March 1997, when the first defendant attended to the second plaintiff, the first defendant noticed a sinus on the left leg of the second plaintiff at the drain site where the second operation was performed. The wound was cleaned and antibiotic was prescribed by the first defendant.
F

[12] On 13 March 1997, the first defendant was informed that the second plaintiff suffered from fits. He referred her for treatment with a colleague, Dr Mohinder Singh, who also practiced in the second defendant's hospital.

[13] Then on 20 March 1997, the first defendant saw the second plaintiff and in
G his notes he recorded that the sinus was still there. He ordered cleaning of the wound and once again prescribed antibiotic.

[14] The first defendant saw the second plaintiff again on 14 June 1997. This time the second plaintiff complained of pain in the femur and numbness. The first defendant in his notes suggested X-ray but to be 'KIV'. Why such delay? The
H explanation offered by the first defendant is that he wanted to evaluate the pain of the second plaintiff. He was also of the opinion that the pain was associated with nerves. Again antibiotic was prescribed.

[15] In between 20 February 1997 and 14 June 1997 according to the plaintiffs, the second plaintiff had her wound cleaned and dressed almost on a daily basis. In
I fact this exercise continued in this manner after 14 June 1997 until 19 March 1998. Occasionally, the first defendant met the second plaintiff in this dressing enclosure when he passed by during one of his rounds.

[16] On 24 June 1997, the first defendant saw the second plaintiff. This time the second plaintiff's daughter accompanied her. This daughter was rather unhappy over

her mother's condition and insisted that the first defendant X-ray the left leg of the second plaintiff where she complained of pain and her wound was not healing. This request was exceeded to and when the pictures were developed the first defendant assured those present that there is nothing wrong with the second plaintiff's leg and advised, once again, that the second plaintiff's wound would heal faster if she were to keep on walking. Again, on this occasion antibiotic was prescribed.

[17] On 21 July 1997, the first defendant once again saw the second plaintiff. This time the first defendant recorded in his notes that the second plaintiff's wound is infected and ordered a pus culture and sensitivity test (C & S). The result of this test would ascertain whether the second plaintiff has a deep infection rather than a superficial infection. It would also enable the first defendant to prescribe the correct treatment.

[18] After 21 July 1997, the second plaintiff did not see the first defendant until the 19 March 1998. This is a lapse of eight months. However, during this period the second plaintiff dutifully, virtually on a daily basis, had her wound cleaned and dressed by the medical assistant at the second defendant's hospital. It was during one of such occasion that the senior medical assistant of the hospital informed her and the first plaintiff that the wound was not healing and that they should seek a second medical opinion. Dr Anantharachagan, a general surgeon who also practiced in the second defendant's hospital, was consulted. X-ray was immediately carried out on 18 March 1998, and Dr Anantharachagan noted that the X-ray showed osteomyelitis. Dr Pasupathy, the medical expert called by the plaintiffs, added that after examining the X-ray ordered by Dr Anantharachagan, he found that the prosthesis in the second plaintiff is loose and 'there is now definite sign of infection in the bone in the femur and the hip cavity. Further to the right side, there is a sign of collection of fluid. This could be pus'.

[19] Aware that the second plaintiff was treated by the first defendant, Dr Anantharachagan referred the second plaintiff back to the first defendant. This time there was a tiff between the plaintiffs and the first defendant. According to the first plaintiff when the first defendant saw the plaintiffs at the dressing enclosure of the second defendant's, the first defendant declared that he would never operate on the second plaintiff again since she is suffering from diabetes and fits. The first plaintiff retorted with: 'you (first defendant) started the first and second operation and you (first defendant) should know that she is a diabetic'.

[20] Now aware of the gravity of the second plaintiff's medical condition and in view of the animosity with the first defendant, the second plaintiff seek alternative treatment from one Dr Low of the Tung Shin Hospital on 20 March 1998. Dr Low, after examining the X-ray ordered by Dr Anantharachagan made the following observations: 'Ray (L) hip showed a (L) Thompson hemiarthroplasty with loose prosthesis and sequestrum with evidence of infection and sequestrectomy'.

[21] Immediately, the second plaintiff was operated on. The prosthesis was removed, and sequestrectomy carried out. This means removal of dead bones. To treat the infection, gentamycin bead was inserted into the wound.

[22] There is no dispute among all medical practitioners called to testify in this case, that what Dr Low did was the correct procedure to treat the second plaintiffs condition, then. In fact, all of them are of the same opinion that subsequent to this

operation, if the patient's medical condition permits another operation should be performed by re-inserting once more a prosthesis into femur. This would enable the patient to walk again. Without the infection, and with the prosthesis properly in place, the patient should suffer no pain when ambulating. However, according to Dr Low, he did not carry out this further operation on the second plaintiff. He cited the following factors which are against the second plaintiff: age, diabetes, epilepsy and past record of infection.

[23] The medical history of the second plaintiff did not end with this operation carried out by Dr Low. About three weeks after the operation by Dr Low, the second plaintiff fell once more. This time, according to Dr Low, the second plaintiff suffered injury to her right pelvis; she fractured her right pelvis. Rest and medication were prescribed while she was at the Tung Shin Hospital between 7 May 1998 to 27 May 1998 for treatment. When she was discharged, the second plaintiff's right hip has healed. However, till date, the second plaintiff cannot walk with assistance. She is without a ball joint to her hip.

Plaintiff's claim

[24] Dissatisfied with the medical treatment, management and care administered by the first defendant during her treatment with the first defendant, and insisting that the second defendant is vicariously liable to the action of the first defendant, the plaintiffs brought this medical negligence suit against these two defendants

[25] Besides, the second defendant is also be sued independently for: (a) permitting the first defendant and other second defendant's hospital staff to continue with a course of treatment on the second plaintiff, which they knew was useless or at best purely cosmetic; (b) failing to provide a system of medical governance and audit for the purpose of the second plaintiffs safety and quality of medical treatment; (c) permitting the first defendant to monopolize the second plaintiff and continue a course of treatment which the second defendant knew or ought to have known was useless.

[26] In the statement of claim, the first plaintiff claims that he is entitled to damages from the defendants as a result of the necessity for him to give up his part time job as a cashier, where he earned about RM1,000 per month in order to look after the second plaintiff. Besides, he is also claiming special damages expanded on the second plaintiff's medical fees.

[27] The second plaintiff's claim is more straightforward. She is claiming for pain, suffering and loss of amenities together with special damages

Approach

[28] It is agreed by all parties that the issue of liability be tried first. If this court finds in favour of the plaintiffs, then the issue of quantum would be litigated.

First Issue: Whether the first plaintiff has a cause of action

[29] In pursuing this claim for and on behalf of the first plaintiff, counsel for the first plaintiff has relied on a passage of *Charlesworth on Negligence* (1962 Ed) which

says: 'In an action for damages for personal injuries, not only may damages be recovered by the injured person but also by a husband who has sustained special damage as a result of the defendant's negligence. A husband can sue for medical and other expenses to which he has been put as a result of personal injuries inflicted on his wife'.

[30] But, I am afraid that the law has since changed. This is best summed up by Justice Chua in*Lai Chi Kay & Ors v Lee Kuo Shin* [1981] 2 MLJ 167 at p 171which says:

> The law as regards the claim of a third party for loss of expense incurred as a result of injury to another person is this. At one time there was considerable support for the view that a person could sue if he had necessarily incurred expense as a result of the defendant's negligence. So, a parent could sue for expense he had incurred through injuries caused to his child by the defendant's negligence. Following the decision in *Receiver for the Metropolitan Police District v Croydon Corporation* [1957] 2 QB 154, the earlier view must be considered erroneous and those cases in support of it wrongly decided. Therefore, in normal run of cases, a third party will have no direct remedy against the wrong-doer. Lord Morton in *Best v Samuel Fox & Co* [1952] 2 All ER 394 considered the situation of a daughter of the injured man having to give up work, which she enjoyed, and stayed at home to nurse a father, who had been transformed into an irritable invalid, as a result of the defendant's negligence, and concluded that she had no right of action against the defendant, since he had not committed a breach of duty towards her. This was because it was a case of the daughter herself suffering a loss and not one of her incurring expense on her father's behalf at all.

[31] This position is the current state of the law as can be observed in the judgment of Justice Lim Beng Choon in *Ahmad Daman Huri bin Hussein v Koo Chin Yau* [1990] 3 MLJ 53 at p 54 where he accepted the dictum of Lord Denning in *Cunningham v Harrison* [1973] 3 WLR 97:

> It seems to me that when a husband is grievously injured — and is entitled to damages — then it is only right and just that, if his wife renders services to him, instead of a nurse, he should recover compensation for the value of the services that his wife has rendered. It should not be necessary to draw up a legal agreement for them. On recovering such an amount, the husband should hold it on trust for her and pay it over to her. She cannot herself sue the wrongdoer (see *Best v Samuel Fox & Co Ltd* [1952] AC 716); but she has rendered services necessitated by the wrong-doing, and should be compensated for it. If she had given up paid work to look after him, he would ctenrfy have been entitled to recover on her behalf; because the family income, would have dropped by so much: see*Wattson v Port of London Authority* [1968] 1 Lloyd's Rep 95 at p 102, per Megaw J. Even though she had not twen doing paid work but only domestic duties in the house, nevertheless all extra attendance on him certainly calls for compensation.

[32] With such clear expression on the current state of the law, I find that the first plaintiff has no cause of action against both the first defendant, as the alleged direct wrongdoer, and against the second defendant, for being alleged to be vicariously liable for the actions of the first defendant.

Second Issue: Whether the second defendant is vicariously liable for the action of the first defendant

[33] As regards to whether the second defendant is vicariously liable for the alleged wrongdoing of the first defendant, three requirements must be satisfied. First, there

must be a wrongful, or tortuous action. Second, there must exists special relationship that is recognized by law between the person alleged to be vicariously liable and the tortfeasor. Third, the tort is committed within the course of employment — *Law of Torts in Malaysia* (2nd Ed) by Norchaya Talib at p 368.

[34] Since the defence of the second defendant centers on the lack of special relationship between the first and second defendants to constitute any vicarious liability, I shall deal with this factor first.

[35] To ascertain whether such special relationship exists, the courts have devised various tests. The first is the control test as laid down in *Short v J & W Henderson Ltd* (1946) 62 TLR 427 at p 429. Here the criterias are: first, the power of selection of the employer; second, power in determining salary or other remuneration; third, power or right of the employer to control the method in which the work was done; fourth, power and right of the employer to terminate the employee's services.

[36] Then there is the organizational test. This is laid down in *Stevenson, Jordan & Harrison Ltd v MacDonald & Evans* [1952] 1 TLR 101 at p 111. Here the court examines the wrongdoer's work in relation to organization set up by the party who is alleged to be vicariously liable for his action.

[37] Finally, there seem to be a third test known as the multiple test adopted by the courts as shown in *Ready Mixed Concrete (South East) Ltd v Minister of Pensions and National Insurance* [1968] 2 QB 497 which is said to be based on the common sense approach.

[38] All in all, what that is necessary for the second plaintiff to establish in this case against the second defendant is that whether the second defendant has a control over the first defendant to create a form of special relationship that can cause the second defendant to be vicariously liable for the wrongdoing of the first defendant, if proven.

[39] Having examined the evidence and applying all the tests as elaborated above, I find that no such special relationship exist to attribute vicarious liability on the second defendant. My reasons are as follows:

(1) The first defendant was, at the material time a consultant with clients of his own. Though he was attached to the second defendant, it was only an arrangement to use the second defendant's facilities such as running his clinic there, and using its operating facilities. For this, the first defendant had to pay and the form of payment was a percentage of the first defendant's charges to his clients. These clients were exclusively that of the first defendant who had a full control in the form of treatment, management, and care to be administered upon them as well as the amount of fees to be charged.

(2) Though there is no denial that when the second plaintiff was first admitted to the second defendant's hospital for treatment, and the second defendant had proposed the first defendant, but this does not mean that the second defendant had control over the first defendant. To me, this exercise was only a recommendation by the second defendant to the second plaintiff to take on the services of the first defendant. The second plaintiff could reject or refuse this recommendation of the second defendant. And similarly, the same option was opened to the first defendant. And when both the second plaintiff and the first defendant agreed to accept each other, they entered into an independent

contract with each other. The second defendant had absolutely no control over the terms and conditions of this contract relating to either the type of services to be provided or regarding the terms of payment for it.

(3) Though the second plaintiff has stressed that the first defendant is or was at all material time a shareholder of the second defendant but he was not in the management of the second defendant. The first defendant was not in control over the affairs of the second defendant. He only practiced medicine by using the premises of the second defendant for which, as stated, he paid for it. At best, being just a shareholder, the first defendant is or was merely an investor. To me, the first defendant was an independent contractor.

Third Issue: Whether the second defendant is independently liable to the second plaintiff

[40] From the evidence adduced, I find no ground to support the second plaintiff's claim that the second defendant was negligent in the form and manner as set out in her claim against this second defendant independently. As explained and decided, the first defendant was at the material time an independent contractor and had his own set up in the treatment, management and care of the second plaintiff. The second defendant only provided the premises and operating facilities for which the first defendant paid for its use. The second defendant had no control over the course or form of treatment, management and care administered by the first defendant on the second plaintiff. If the second plaintiff was not satisfied with the services of the first defendant she could change to another doctor or specialist. She had a free choice. This is borne out by her seeking the advice from Dr Anantharachagan. It was, in my view, out of professional ethics that Dr Anantharachagan referred this case back to first defendant, as well as the fact that he was not an osteopathic surgeon; he was only a general surgeon.

[41] Regarding claims that the second defendant's staff had continued with a course of treatment which the second defendant's servants and agents knew or ought to have known was useless or at best purely cosmetic, I am of the view that minus the first defendant, the only other people who attended to the second plaintiff from the second defendant were: (a) the operating staff; (b)the nurses at the ward; (c) the medical attendants who dressed her wound and; (d) the physiotherapist. In respect of the first two categories, there is absolutely no evidence led by the second plaintiff against them. But when questions were posted to the second plaintiff as well as her relevant witnesses as to whether they were satisfied with the services so provided by the later two categories, they all answered in the positive. And in any event, the dressing by the second defendant's medical assistants on the second plaintiff as well as those exercises encouraged by the physiotherapist on the second plaintiff were all done on the instructions of the first defendant.

[42] For these reasons, I find that the second defendant is not liable to the second plaintiff as claimed.

Fourth Issue: Is the first defendant liable to the second plaintiff for negligence

The law

[43] To decide on this, it is necessary from the outset to lay down the law relating to medical negligence.

[44] The Justices of the High Court of Australia in *Christopher Rogers v Maree Lynette Whitaker* [1993] 1 CLJ 449 at p 450 has correctly stated the following:

> The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment' (*Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871, per Lord Diplock at p 893); it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case (*Gover v South Australia* (1985) 39 SASR 543 at p 551.

[45] And based on what standard of proof is answered by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 and re-affirmed in *Dr Soo Fook Mun v Foo Fio Na & Anor and another appeal* [2001] 2 MLJ 193 to be applicable in this country. It is:

> The standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art ... in the case of a medical failure to act in accordance with the standard of reasonably competent man at the time.

Analysis

[46] Having set out the law, I shall now proceed to analyze the facts.

First operation

[47] The second plaintiff complained that her present condition is due to the first defendant's negligence that commenced from the first operation. To support this, Dr Pasupathy, a osteopathic surgeon attached to the Pantai Hospital in Kuala Lumpur claimed that from a post X-ray photo taken of the second plaintiff after the first operation, he noticed that the prosthesis was not properly seated against the calcar. There was a gap between the shoulder of the prosthesis and the calcar. This could be caused by insufficient reaming of the femur to fit the prosthesis. In addition, he noticed that cement was not used to secure the prosthesis in the femur. The use of bone cement for such operation, in his opinion, is common among the surgeon he worked with. When the prosthesis was not properly fitted, Dr Pasupathy claimed that the patient would experience pain.

[48] The first defendant disagreed with the finding and opinion of Dr Pasupathy. First, he said that the application of bone cement was not universal among orthopedic surgeons performing a Thompson hemiarthroplasty, since firstly, it involved another step in the procedure; secondly, the use of bone cement has a disadvantage when it comes to removal in the event of a revision; thirdly, there is the risk of infection since foreign object is introduced into the body. The first defendant maintained that if the prosthesis fits adequately, there is no necessity to apply bone cement.

[49] Over the claim of a gap between neck of the prosthesis and the calar, the first defendant explained that the X-ray photo could not support this since it is only a two dimension reflection. He is of the view that this photo shows a well fitted prosthesis.

[50] To support the first defendant's aforesaid views is Dr Charles V David, another orthopedic surgeon attached to the Subang Medical Center. He is a witness for the first defendant.

[51] I tend to agree with the opinion of the first defendant and that of Dr Charles V David. First, the use of bone cement in a hemiarthroplasty operation is not a universal practice among orthopedic surgeons. I accept that if the prosthesis is well fitted then there is no need for such application. After all, there are consequences that may arise if one uses cement. It all depends on the judgment of the surgeon who did the operation to decide whether to apply or disregard. In this case, the first defendant had exercised his professional judgment and I accept his discretion.

[52] On the claim of a misfit prosthesis, I am of the view that the X-ray photo, as explained, being limited to a two dimension reflection cannot conclusively tell whether there is a gap between the neck of the prosthesis and the calcar.

[53] And as for the pain experienced by the second defendant, this could have been post operative pain. It might not have been caused by the loosening of the prosthesis. This seems to be somewhat confirmed by the first defendant's medical notes recorded during this period which says that the second plaintiff was able to walk.

Second operation

[54] X-ray of the pre-second operation shows: fracture of the lesser trochanter; the prosthesis has moved downwards to the femur; there is a cavity on the upper (greater) trochanter; and the prosthesis is unstable.

[55] For this operation, the first defendant used bone cement and to firm it up he manually held a gauze over the relevant parts until the cement was dry and firm. According to the first defendant, bone cement was preferred on this occasion because this is the second plaintiff's second operation over the same area and for the prosthesis to be more secure this adhesive provides the solution.

[56] Dr Pasupathy, though accepting the use of bone cement for this second operation was correct but more should be done. He is of the view that wires should be strapped over the lesser trochanter to give further reinforcement. This would be better than the manual application of a gauze over the area. Further, he feared, as proven subsequently, according to him, a spillage of the bone cement into the soft tissue of the second plaintiff giving rise to a deep infection.

[57] Over this procedure for this second operation, I do not think there is much argument or differences of significance. This means, a surgeon can either uses wires or manually holds together the bone in the area. But what is more important is whether there was spillage of bone cement into the soft tissue, which could give rise to a deep infection.

[58] Dr Low who performed the third operation, found these: the prosthesis loose and sequestrum with evidence of infection. He then carried out sequestrectomy which 'is removal of dead bone'. Dr Pasupathy however maintained that what Dr Low removed were bone cement rather than dead bones. This view seems somewhat shared by Dr Charles V David when he examined the post-operative X-ray of the second operation taken on 4 February 1997. He confirmed that 'that there are

particles of what look like bone cement ... they are around the calcar and below the neck of the prosthesis'. To a large extent, this view seems to be concurred by the first defendant himself. But even with the presence of bone cement in the soft tissue, this may not give rise to an infection, except that the chances are greater. There may be other causes for the infection. But even accepting this, could such infection, and the extent of it, be diagnosed by the first defendant at the earliest opportunity so that appropriate treatment can be prescribed. On this, my finding is in the negative.

[59] My reasons are as follows. If one examines the chronology of events against the back drop of the medical history of the second plaintiff, the first defendant should have been able to diagnose the pain complained of by the second plaintiff from the operated area and the wound which refuses to heal as that of a deep infection, and should have treated it immediately. The manner of treatment, as agreed by all those medical personalities who presented their evidence relevant to this point, is the procedure carried out by Dr Low in the third operation. After the second operation, the second plaintiff had experienced discharges from her wound. She has also complained of a deep thigh pain. Besides, a sinus was also discovered. There were even discharges where at time, the hospital attendant dressing the second plaintiffs wound had to use a wick to soak up the discharges. The wick was used in order to get to the deeper reaches of the wound. Despite these, the first defendant continued to prescribe antibiotics. With such indications, I accept the view of Dr Pasupathy that as early as March 1997, the first defendant should have called for a C & S test. This would disclose whether the second plaintiff had a superficial wound or a deep seated one, But the first defendant procrastinated. Besides, there was no X-ray taken of the second plaintiff, which may be another form of investigation into the seriousness of the second plaintiff's medical condition until insisted upon by the second plaintiff's daughter as late as 24 June 1997. And even after such X-ray was developed where the first defendant admitted in evidence the presence of bone cement outside the femur that he should have removed during the second operation, the first defendant was unable to ascertain that the second plaintiff was suffering from deep infection of her left leg. This is borne out by the advice of the first defendant to the second plaintiff to continue walking and that there is nothing wrong with the second plaintiff. Surely, the first defendant would have suspected by then that these foreign objects may be the culprit of the recalcitrant wound. These delayed actions of the first defendant in diagnosing and treating the second plaintiff, I find, amounts to negligence on the part of the first defendant.

[60] The first defendant main defence over all these is that the second plaintiff did not return to see him for treatment. But if one were to examine the chronology of events again, this is not correct. After the second operation, the second plaintiff had been very regular at the first defendant's clinic. This went up to 20 March 1997. Then there was an absence of about three months until the next clinic visit to the first defendant on 14 June 1997. But on the 20 March 1997, the first defendant had advised the second plaintiff to continue with daily dressing. This advice, the second plaintiff obediently followed and on many occasions during such dressing, the first defendant examined and made inquiries from the medical attendants dressing the second plaintiff with regard to the second plaintiff's wound. Thus, this so-called lapse of three months is not really a complete absence of the second plaintiff from the first defendant's care.

[61] On the clinic visit of 14 June 1997, the first defendant continued to diagnose the pain in the deep left thigh of the second plaintiff as nerve pain. Despite of this, he 'KIV' X-ray on the second plaintiff. It was not until the next visit on 24 June 1997, that the first defendant relented to have the second plaintiffs leg X-rayed, This was, as disclosed, at the insistence of the second plaintiff's daughter. This time despite X-ray taken, the first defendant was still unable to detect the infection. To the contrary, he assured the parties present that nothing was wrong with the second plaintiff.

[62] The clinic visit that followed was 21 July 1997. This time a C & S test was conducted but the first defendant never instructed the second plaintiff to return for the next appointment, which the medical practitioners who testified in this case agree should have been done in normal circumstances. Without such appointment, the second plaintiff continued with her daily dressing as advised and approved by the first defendant. This lasted for about eight months until she acceded to the advice given by the medical attendant to seek another medical opinion. And on the 19 March 1998, after the first defendant became aware of the second plaintiff's visit to Dr Anantharachagan he refused to treat the second plaintiff. Though there may be this time period of eight months between the clinic visit of 21 July 1997 to 19 March 1998, it was not, in my view, due to the fault of the second plaintiff for refusing to see the first defendant. The first defendant had assured her and her family members all along that there was nothing wrong with her, and this was even having examined the X-ray pictures on the 24 June 1997, and not fixing another appointment on 21 July 1997 for follow-up visit. As I have stated earlier, despite this absence from clinic visit, the first defendant still saw the second plaintiff at the dressing enclosure of the hospital. From the totality of these facts, I am of the view that the first defendant cannot use this excuse of long absence to exempt himself from liability when in the first place he had failed to diagnose the deep infection in the left thigh of the second plaintiff which was most likely caused by the bone cement left or spilled into the soft tissue during the second operation as a result of his act at the earliest date when he examined the second plaintiff who persistently complained of pain in her left thigh couple with continuous discharges from her wound.

[63] The first defendant advanced the reason that the second plaintiff was parsimonious when she refused to see him for such long periods and instead preferring to a less expensive alternative: being dressed by the hospital attendant. I cannot accept this accusation as proven. Firstly, the second plaintiff had frequently sort the services of the first defendant, but the first defendant has constantly and repeatedly advised the second plaintiff to continue with such dressing. Obediently, as I have stated, the second plaintiff complied to the very end. Secondly, as evidence revealed, these hospital assistants do report back to the doctor who referred the patient to them, and as disclosed, the first defendant had also seen the second plaintiff occasionally during these dressing sessions. Thirdly, these dressings do not come free. The second plaintiff or her husband, the first plaintiff paid for them. And if you consider the number of days expanded on this, the amount cannot be said to be insignificant.

A

Findings

[64] For the reasons as stated, I find that the first defendant was negligent in treating, managing and caring for the second plaintiff and is therefore liable to pay her damages which is to be assessed.

B

Conclusion

[65] I thus allow the second plaintiff's claim against the first defendant for only general and special damages to be assessed by the Senior Assistant Registrar of the High Court in the Civil Division in Kuala Lumpur. There shall also be interest as claimed on the sum assessed and costs.

C

[66] I dismiss the first plaintiff's claim against both defendants with costs. I dismiss the second plaintiff's claim against the second defendant with costs.

D

First defendant found negligent and liable to pay damages to second plaintiff.

Reported by Peter Ling

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